Design a Delivery System for Better Care in West Virginia

Keeping in mind the existing resources and programs to address obesity and related chronic diseases from the West Virginia Bureau for Public Health presentation and contained in the "Better Health / Care Launch Document," your task is to provide the design considerations for a delivery system that will encourage Better Care in West Virginia. A hypothetical vignette is provided below. ***This hypothetical vignette is a tool to stimulate discussion; it is not necessarily an endorsement of that system design by the SIM grant.*** *Today's focus is primarily on addressing obesity and co-morbid chronic diseases, such as diabetes, hypertension and CVD, but the delivery system might also be a good fit for supporting reductions in tobacco use and substance abuse.*

Hypothetical Vignette

Transitioning from the current fragmented, fee-for-service system to a functional coordinated care system will take time, resources, training, education and support. Despite these barriers, assume that all West Virginia public payors (i.e., Medicaid, PEIA and WV CHIP) and private payors agreed to transition by 2021 to a value-based model that delivers the triple aim of health care. To meet the triple aim, further assume that the payors decided to reimburse for Medical Neighborhoods,[1] which are linked to primary care medical homes. These Medical Neighborhoods may consist of one integrated system under single management, such as the state or a non-profit organizer, or as a network of individual entities linked by collaborative agreements. The Medical Neighborhoods could also be linked to regional integrated systems of care and leverage community-based health resources through a statewide "virtual" care coordination network that provides access to health improvement resources (e.g., diabetic educator, dietician, social worker), particularly in small and rural practices.

In this hypothetical vignette, the Medical Neighborhood is required to offer basic primary medical care, behavioral health, oral health, pharmacy services and care management. Specialty care and extended care in any area must be coordinated and managed by, and through, the Medical Neighborhood. Furthermore, the Medical Neighborhood will be responsible for care coordination; patient engagement and satisfaction and achievement of care goals. The Medical Neighborhood will also have fiduciary responsibility for expenses and reimbursements.

[1] A "medical neighborhood" is a set of specialists and other providers who provide health care services to the patients who are part of a primary care medical home. Definition source: Center for Healthcare Quality & Payment Reform.

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Targeted Populations and Interventions

- You should identify the target populations to be addressed by the interventions.
- You should discuss the number and types of providers or potential number of participating providers that are needed to address the health improvement objectives.
- You should identify the services that should be delivered; how they can be most effectively and efficiently delivered and how current barriers to health can be addressed through such delivery.
- You should build on the current programs and evidenced-based interventions described by the WV BPH, CMS and / or CDC.

Design Constraints

Your design efforts should be consistent with the goals established by the SIM Steering Committee. Four aims were previously identified and endorsed by the SIM Steering Committee. These aims will be completed to meet the overarching goals of the SIM grant, as well as the long-term goal of improving the West Virginia health care delivery system. These aims include:

- Establish a highly coordinated care delivery system built upon a comprehensive primary care model;
- Implement payment systems developed to enhance value for consumers;
- Adopt population health improvement strategies that address existing health disparities, modifiable risk factors and preventable conditions and
- Expand the use of information technologies to provide better intelligence to providers and other stakeholders.

Additionally, you should be mindful of the following:

- You might not have funding to implement your model, so it should be as self-sustaining as possible.
- The model should prioritize interventions based on improvement goals.
- The model should demonstrate savings within five years and be fully-deployed within a decade.
- If there are state laws that need to be repealed, revised or passed to make your model practical, identify those. Keep in mind there is no guarantee this will happen, and it weakens the ability of the model to be implemented if there is a lot of legislative change required.
- Prioritize pre-existing policy levers, such as revising agency rules, submitting a Medicaid State Plan Amendment or applying for a waiver from CMS.
- **You MAY NOT change federal law, or attempt anything contrary to state or federal law.**

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Reminder of Workgroup Consensus

The workgroup adopted consensus statements after the July workgroup meeting through its survey process. You should keep those in mind when designing the system. Please see the handout entitled **"Better Care Workgroup July Survey Results"** for reference.